Chiropractic and Health Center

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CHIROPRACTIC AND HEALTH CENTER FINANCIAL POLICIES

We are committed to provide you with the best possible care and we are pleased to discuss professional fees with you at any time.

- We require payment is made at the time of service rendered.
- If you are unable to keep your appointment, you must give **24 hours** notice otherwise **$40.00** fee will be charge. Once an appointment is made, please remember that costly time has been reserved for you.
- Our office will give a first warning for not complying with 24 hours notice policy but will charge on the next missed appointment.
- Any returned checks and/or bounced checks a fee of **$35.00** will be assessed.
- The patient agrees to be fully responsible for total payment of procedures and services rendered in this office, including any treatments not covered by the health insurance company. I understand that I am financially responsible for any charges that my insurance policy does not cover. Should collection measures be taken against me for failure to pay outstanding balance due to professional services received and/or failure to reschedule my appointment within 24 hours in advanced. I agree to pay all collection fees.
- Failure to be financially responsible for any outstanding balances will result in 18% per annual interest accruing 30 days from the issuance date of the statements and for any and all collection costs or fees, including but not limited to 35% attorney's fees and court costs if the account are turned over to a third party and/or attorney for collection.

In instances of repeated **non-compliance** with your scheduled visits, we also reserve the right to discontinue your care and will inform your other physician/ attorney and any professional involved in your care/treatment of the fact that your service has been discontinued due to **non-compliance** with the treatment plan recommended by Dr. JeYoung Yun, D.C.

I HAVE READ AND FULLY UNDERSTAND THE TERMS OF THIS POLICY.

Patient Name (Print) _____

PATIENT'S SIGNATURE _____ **DATE:** _____
(Parent/guardian if patient is a minor)

Witness Name: _____ **DATE:** _____

Effective 8/1/13